take care clinic℠
at select Walgreens

Take Care Clinic Voucher for Humana Vitality

Body Mass Index (Height & Weight)	Blood Pressure
Cholesterol Screening *	Glucose Screening *
Waist Circumference	Tobacco Use (Current Smoker or Non-Smoker)
Individual Patient Report	One-on-One Counseling with Take Care Health Provider

*** For the Cholesterol and Glucose Screenings, fasting 9-12 hours prior to your screening is encouraged. To the extent your health permits, no food should be consumed during this time but we strongly encourage you to drink plenty of water.**

Please visit www.takecarehealth.com or call 866-Take-Care (866-825-3227) to find the Take Care Clinic closest to you and to check current wait times.

1. When visiting the Take Care Clinic, please bring this **Take Care Clinic Voucher** along with **Photo Identification** (example – Drivers License).
2. **Sign in at one of the touch-screen kiosks** and follow through a series of screens. Select "Health Screening/Biometric Screening (18+)" when prompted.
2. Next, when prompted please select **"I have a voucher, special offer or gift card"** on the touch screen.
3. Please present this Voucher to the Take Care Health Provider at the beginning of your visit so that we can ensure the appropriate services are performed. The Take Care Health Provider will collect this Voucher from you.
4. You will owe $0 at the end of the visit
5. Patient must complete a Release of Information Form to consent to release information to Concentra Health Services, Inc.
6. If a completed Release of Information Form is required to participate in your employer program and utilize the voucher and the patient does not complete a Release of Information Form, the voucher is no longer applicable and the patient may proceed with the testing by providing an alternate means of payment.

Take Care Clinics are professional, walk-in healthcare clinics located at select Walgreens. We are open seven days a week, including weeknights, and appointments are available. Each clinic is staffed by board certified Family Nurse Practitioners and Physician Assistants who diagnose and treat a variety of common ailments such as coughs, colds, fevers, seasonal allergies, skin conditions, and minor injuries. We also offer select vaccinations and physicals, as well as wellness offerings. Take Care Clinics offer an innovative approach to quality, everyday family healthcare built around you – the patient.

For Take Care Health Provider

Company Name: **Humana Vitality**
Promotional Code(s): **HUVT**
Markets: **National**
Services: **80061, 82962, 99401**
Valid Dates: **7/1/2011 – 2/15/2013**
Cost to Patient: **$0**

Take Care Health Provider must scan this voucher and completed Release of Information form into the patient record.
Please be sure that all points of care including: Height, Weight, BMI, Blood Pressure, Waist Circumference, Total Cholesterol, HDL, LDL, Triglycerides, Total Chol / HDL ratio and Glucose are performed.
Provider must also ask the patient regarding tobacco use and document under the Intake Questionnaire.
All data must be entered into the EMR.

This voucher only applies to the services and promotional codes listed above. All other Take Care Clinic services are to be charged at standard rate.

RELEASE OF INFORMATION FORM

take care health systems

PLEASE MAIL OR FAX COMPLETED FORM TO:
Take Care Health Systems, LLC
Attn: PSC – ROI Department
4165 30th Avenue SW, Suite 101, Fargo ND 58104
Phone: 866.825.3227 Fax: 701.277.0352

RELEASE OF INFORMATION
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. I understand Take Care Health Systems, LLC, has 30 days to respond to this request.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Release to: Concentra Health Services, Inc.

If this form is being completed by patient or guardian a copy of your PHOTO ID is required

Name/Business: Concentra Health Services, Inc.

Address: 5080 Spectrum Drive, Suite 1200 West

City, State, Zip: Addison, Texas 75023

Phone Number: xxx-xxx-xxxx Fax Number: xxx-xxx-xxxx

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

The results of my Biometric Testing.

EXPIRATION DATE

This Authorization will expire one (1) year from the date of your signature.

PURPOSE OF THE USE AND DISCLOSURE

For the purpose of updating my wellness profile with the results of my Biometric Testing and for health plan design.

PATIENT AGREEMENT

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not my health plan or my health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I release Take Care Health Systems, LLC, from all legal responsibility and/or liability that may arise from the release of the records I have specified.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken with reliance on it.

I authorize Take Care Health Systems, LLC, to use or disclose of protected health information as described above.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Personal Representative Relationship to the patient and representative's authority to act on behalf of the patient